43 Norman JN, Ledingham IMcA. Carbon monoxide poisoning: investigations and treatment. *Prog Brain Res* 1967;**24**:101-22.
44 Sluijter ME. The treatment of carbon monoxide poisoning by administration of oxygen at high atmospheric pressure. *Prog Brain Res* 1967;**24**:123-82.
45 Takano T, Miyazaki Y, Nashimoto I, Kobayashi K. Effect of hyperbaric oxygen on cyanide intoxication: in situ changes in intracellular oxidation reduction. *Undersea Biomed Res* 1980;**7**:191-7.
46 Isom GE, Way JL. Effects of oxygen on the antagonism of cyanide intoxication: cytochrome oxidase, in vitro. *Toxicol Appl Pharmacol* 1984;**74**:57-62.
47 Smith G, Sharp GR. Treatment of carbon monoxide poisoning with oxygen under pressure. *Lancet* 1960;ii:905-6.
48 Mathieu D, Nolf M, Durocher A, *et al*. Acute carbon monoxide poisoning. Risk of late sequelae and treatment by hyperbaric oxygen. *J Toxicol Clin Toxicol* 1985;**23**:315-24.
49 Myers RAM, Linberg SE, Cowley RA. Carbon monoxide poisoning: the injury and its treatment. *Journal of the American College of Emergency Physicians* 1979;**8**:479-84.
50 Klindwall EP. Hyperbaric treatment of carbon monoxide poisoning. *Ann Emerg Med* 1985;**14**: 1233-4.
51 Fishman RA. Brain edema. *N Engl J Med* 1975;**293**:706-11.
52 Sukoff MH, Ragatz RE. Hyperbaric oxygenation for the treatment of acute cerebral edema. *Neurosurgery* 1982;**10**:29-37.

Psychiatry: private and public provision

Conditions seem favourable for further expansion in private acute psychiatric care. The government is encouraging managers of district and regional health authorities to seek closer cooperation between the National Health Service and private providers, and the generally low standard of NHS provision is undoubtedly an incentive for those who can afford it to seek private treatment. Counselling for people with psychiatric problems is already highly commercialised. Three questions arise from the expansion in private psychiatry: What is happening in the private psychiatric sector? What effects are current resource constraints having on NHS psychiatry? What form of coexistence between private and public provision will prove most effective and efficient?

The market in private acute psychiatric treatment is still small,[1] largely because people with mental illness descend down the social scale. In addition, insurance risks are high, and until recently private treatment was provided mainly in a few hospitals remote from most of the population. At the same time, private practice among NHS consultants has remained undeveloped, focusing mainly on the outpatient treatment of patients with neuroses.

Now the number of consultant psychiatrists working in the private sector and the number of private hospitals are increasing, predominantly in the more affluent south. Unlike in the NHS, morale is high and the facilities are usually impressive. In 1980 there were 25 full time private psychiatrists in England and Wales; by 1986 there were 60. In addition, 300 consultants had by 1986 developed a substantial commitment to private practice.[2] There are over 20 private psychiatric hospitals with almost 2000 beds (10% occupied by chronically ill patients).[2] In all, about 4% of beds for patients with acute mental illness are private (compared with about 10% of beds for elective surgery).[1]

Commercial and financial information on private medicine is difficult to obtain,[3,4] but it has been estimated that in 1984 private acute psychiatry was generating a return of around £25m annually (compared with about £500m for acute general hospital care).[1] Since the early 1980s the domination of this market by British charitable institutions has been increasingly challenged, particularly by a few American multinational companies, which are now responsible for about half the total cash turnover.[3] Their investment and the resulting competition has affected the pattern of provision. For example, consultant private practice has moved away from the conventional "closed" model of psychiatric inpatient care, with treatment being provided entirely by full time hospital staff, to an "open" model in which local consultants have admitting rights.

How resource constraints are affecting NHS psychiatry is uncertain and likely to remain so—mainly because the necessity for, and sufficiency of, psychiatric treatment is hard to quantify. Furthermore, ideological differences among both providers and consumers lead to contradictory judgments,[5] as can be illustrated by events at the Bethlem Royal Hospital and the Maudsley Hospital and at the Institute of Psychiatry. Last year a group of doctors and academics wrote to *The Times*: "The government's conjoint undermining both of the universities and the NHS constitutes an immensely threatening pincer movement on this centre [and] is a devastating attack on the core of British psychiatry and on the future care of a vulnerable sector of the community. Our financial crisis has meant that of the last eight academic posts to fall vacant at the Institute, only one could be filled, and three university chairs have been lost. The Bethlem/Maudsley are at the same time faced with a £400 000 per year deficit which will require drastic cuts in patient services."[6] This year the chairman of the Joint Hospital Special Health Authority replied to subsequent similar criticism[7]: "The financial crisis is not the same and the deficit has been reduced from £1.4 million to £367 000. Cuts are not inevitable and are indeed not foreseen."[8] He added that since 1979 the joint hospital had opened four new units at a total revenue increase of £3·3m; in addition, a new unit for computed tomography opened last year, and building has started on a first block of new wards (at a capital cost of £3·7m).

The eventual mix between private and public mental health care will be resolved by market forces and empirical means. Meanwhile, a key NHS objective continues to be to provide cost effective treatments that are flexible and responsive to changing circumstances. Psychiatric treatment is heterogeneous, and the therapeutic value of most of its components has not been proved. The NHS thus cannot hope to provide all specialist psychiatric services, and Professor Sydney Brandon asked in his recent report on a "subversive foray into private practice": "Do we have to recognise that certain kinds of care such as some or all of secure accommodation, the management of the severely head injured, psychosexual counselling, intensive psychotherapy or long term social skills training cannot be provided as basic care and have to be contracted out or sought privately?"[2]

GREG WILKINSON

Senior Lecturer,
General Practice Research Unit,
Institute of Psychiatry,
London SE5 8AF

1 Laing W. *Private health care. Studies of current health problems No. 79*. London: Office of Health Economics, 1985.
2 Brandon S. Conference report: a subversive foray into private practice. *Bulletin of the Royal College of Psychiatrists* 1987;**11**:23-4.
3 Fitzhugh W. *The Fitzhugh directory of independent hospitals' and provident associations' financial information*. London: Healthcare Information Services, 1986.
4 Grant C. *Private health care in the UK: a review. Special report No. 207*. London: The Economist Intelligence Unit, 1985.
5 McLachlan G, Maynard A. The public/private mix in health care. The emerging lessons. In: McLachlan G, Maynard A, eds. *The public/private mix for health. The relevance and effects of change*. London: Nuffield Provincial Hospitals Trust, 1982.
6 Edwards G, Gunn G, Gray G, *et al*. Fears for leading psychiatric centre. *The Times* 1986 May 27:13 (col 4-5).
7 Lewis G, Appleby L. Doubts about keeping NHS safe. *The Times* 1987 May 22:17 (col 4).
8 Clout IR. Maudsley measures. *The Times* 1987 May 29:13 (col 4-5).